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ABSTRACT

This paper presents an approach to crisis intervention which was developed for use with acutely disturbed patients requesting therapeutic services at the Marin County Community Mental Health Center in California. Assumptions of the intervention approach which center on the crucial role played by unconscious guilt in both psychopathology and patients' reactions to crises are explained. The view that crises reconfirm a patient's pathogenic beliefs and thereby exacerbate his unconscious guilt is discussed. A crisis intervention technique is described which involves: (1) continuing the initial interview until some explanation of the psychopathology is found; (2) formulating the psychopathology of patients in crisis by drawing on all relevant sources of data including history, current life problems, and the patient's testing of the therapist; and (3) offering the patient a dynamic evaluation which includes interpretation about the role of unconscious pathogenic beliefs and guilt in his reaction to the crisis. Factors contributing to treatment effectiveness in the crisis intervention setting are presented and the range of applicability of the approach is considered. A case example is provided and discussed which illustrates the orientation and approach of this crisis intervention technique. (NRB)

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A CRISIS INTERVENTION APPROACH STRESSING EARLY INTERPRETATION OF UNCONSCIOUS GUILT

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Introduction

The approach to crisis intervention to be described here was developed at the Marin County Community Mental Health Center in California. The patients seen were acutely disturbed and requesting emergency therapeutic services.

The approach was influenced by the work of Joseph Weiss, discussed here today by Marshall Bush. In my view, unconscious guilt stemming from pathogenic beliefs plays a crucial role in most forms of psychopathology and certainly in patients' reactions to crises.

Crisis Intervention - Assumptions

This approach to crisis intervention makes the following assumptions: Crises reconfirm a patient's pathogenic beliefs and thereby exacerbate his unconscious guilt. The intensification of unconscious guilt immobilizes the patient and consequently lessens his ability to deal with the crisis. Where patients are assisted through crisis intervention to gain control over their unconscious guilt, their capacity to deal effectively with the crisis is often restored. The most effective approach to help patients gain control over their unconscious guilt is to assist them in gaining insight into the unconscious pathogenic beliefs that are the source of the unconscious guilt.

Crisis Intervention - Methods

Identification of current sources of stress in patients in crisis is a necessary part of understanding how pathogenic beliefs contribute to the development of their disturbance.

It is also critical to obtain dynamic historical information relevant to the origins and development of the patient's pathogenic beliefs and unconscious guilt in order to provide effective treatment. Information about child-parent and sibling relationships and about important childhood traumas is particularly helpful for understanding the sources of unconscious guilt.

It is easy to underestimate the capability of patients in crisis to be insightful about their problems. Our experience has been that the patients we have seen are usually able to produce early childhood material and to work in an insight-oriented way. It is as if the crisis permitted them greater access to their childhood memories, as well as to their irrational beliefs. These patients often seem to have great awareness of the relevance of their childhood traumas and their irrational beliefs for benefitting from crisis intervention therapy.

The nature of the patient's interaction with the therapist may also provide relevant information about unconscious guilt. Weiss has pointed out two important patterns of interaction. One he calls "transferring", the other "turning passive into active." Both serve the purpose of testing the therapist to ascertain whether the treatment relationship provides adequate safety for the patient to move towards important life goals and to disconfirm his unconscious pathogenic beliefs. Understanding the way in which the pa-

tient is testing the therapist is useful diagnostically. The form such testing takes suggests the nature of the pathogenic beliefs with which the patient is struggling. This information can then be interpreted to the patient in order to further his understanding of why he is in a crisis. An awareness of the nature of the patient's tests also helps the therapist to be more able to correctly pass them and thereby improve his therapeutic effectiveness. This may be particularly useful in crisis work where one must decide, often without clear criteria, whether or not it would be helpful to a patient to use such interventions as being overtly supportive, giving advice, or using environmental manipulation. Consider the latter. There are patients who demand hospitalization or medication to reduce their distress. Perhaps they describe symptoms of depression including suicidal thoughts. In some cases granting such requests would provide the treatment of choice and would lead to a successful outcome. In other instances, this form of treatment may be contra-indicated and would lead to a worsening of the patient's condition.

For instance, there was a case in which a black professional woman repeatedly cried and pathetically insisted she felt so depressed that nothing short of hospitalization could help her. She said she was stressed by overwork and disagreements with her partner. She protested she just couldn't handle things anymore.

During the course of an extended initial consultation, it emerged that this patient was an extremely successful member of a family in which others had suffered great adversity. Both parents were alcoholic, one sibling had been murdered and a second was a heroin addict. The patient apparently felt she did not deserve to have done so well in comparison with others in her family. Her guilt about being better off than other family members was reinforced by her view that her mother was envious of her competence and successes.

Her request for hospitalization represented an attempt to test the therapist to see if he, like her mother, might need to treat her as if she were a person who could not cope and did not deserve to continue being successful. When he steadfastly refused this request, she protested. However, upon leaving the interview she seemed pleased and indicated she was feeling a little better. In a follow-up call ten days later the patient stated that she was no longer feeling depressed and enthusiastically described ways she had found to deal more effectively with her problems. The therapist in refusing to hospitalize the patient had passed her test.

Another patient in crisis might also convey a great sense of distress and indicate that he does not deserve to live. He might imply that he is considering suicide and ask if he should be hospitalized.

In this case the therapist might conclude from his diagnostic findings that the patient experiences unconscious guilt when he desires help, and he is testing the therapist to determine whether the therapist believes that the patient deserves to be taken seriously, deserves to be protected from his suicidal impulses and deserves to be given a chance to live.

If the therapist does take the request for hospitalization in earnest and acts accordingly, the patient may perceive the therapist as passing the test.

The patient may then either be able to get by without hospitalization, or will benefit greatly from it.

A technique we believe to be extremely useful in working with patients in crisis is to continue the initial interview until we have arrived at some explanation of the psychopathology. Sometimes this takes two hours or longer.

Our formulation of the psychopathology of patients in crisis draws on all relevant sources of data including history, current life problems, and the patient's testing of the therapist. The patient is then offered a dynamic evaluation which includes interpretations about the role of unconscious pathogenic beliefs and unconscious guilt in his reaction to the crisis.

When patients seem unable to integrate all of the interpretative material available, then we focus on the unconscious conflicts most responsible for current symptoms.

Findings

The main goal of crisis intervention has generally been to return the patient to the level of functioning he had attained before the crisis. We have found that our approach not only provides symptomatic relief but can also lead to the start of personality change. Our patients seem to begin to experience a greater sense of control over their lives. If they continue beyond the first treatment session, they may report the onset of changes in their feelings or the belief that they can now become more able to alter their behavior in significant ways.

Some of our patients stop coming after one to several sessions, even though further therapy might significantly improve their functioning. This raises the question as to why patients would terminate a process which is helpful to them. One explanation may be that some of our patients never have had the goal of long term therapy and wish only to return to their previous level of functioning. Once they feel they have accomplished or are on the way to accomplishing this, they may end their treatment. A second explanation for early termination in the patients we have seen is related to guilt. The same unconscious pathogenic beliefs that led to their guilt and symptom formation may inhibit their freedom to fully avail themselves of psychotherapy. They do not feel they deserve all of the happiness or the success or the other positive benefits that they could obtain with treatment.

Others choose to make use of long term psychotherapy, at our agency or elsewhere. It has been our finding that during the course of this psychotherapy some or all of the symptoms may return as the patient attempts to further resolve his unconscious conflicts. However, the symptoms are less intense and patients feel more in control of their behavior.

Factors Contributing to Treatment Effectiveness in this Crisis Intervention Setting

The use of this approach has had some dramatic results. The rapid changes which have sometimes occurred in patients are not in keeping with one's usual

experience in doing psychotherapy. Consequently, the outcomes may seem magical or may seem explainable as a flight into health. We do not believe this to be the case, and we suggest instead that the following factors adequately explain the effectiveness of treatment at our emergency psychotherapy facility:

To begin with we believe that certain characteristics are more common to patients in crisis than to other patients and they can be made use of to hasten improvement. Such patients are generally more motivated to change. They feel out of control and therefore have an intense desire to understand themselves and master their symptoms. They also often seem to have a greater access to early childhood memories which can be used to help comprehend their pathology. Furthermore, patients in crisis generally appear more open to viewing the problem as within themselves. They are more willing to face their most dangerous internal conflicts. These patients are also prone to believe the therapist to be a powerful source of help and therefore are more expectant that he will assist them to change. Perhaps in some cases this is because patients who are experiencing great distress feel more entitled to help.

We believe that the approach to crisis intervention described here is effective in part because it seeks to take advantage of the general characteristics of patients in crisis just described, but that it is primarily effective because it is oriented towards understanding the role of unconscious guilt in the patient's psychopathology.

We find that the patients we see are not only seeking immediate relief, but are also motivated to work on disconfirming the unconscious beliefs responsible for their internal conflicts. Our patients consistently test the therapist in an attempt to disconfirm such pathogenic beliefs. When the therapist passes an important test, patients are not only likely to bring forth additional material, but also seem more receptive to the interpretations made. Such interpretations may then provide great relief. The patients' responses to these interpretations suggest not only that they are coming to understand themselves better than they have before, but also that they feel relieved at being understood with respect to an issue of great importance for them. A frequent response to an interpretation regarding pathogenic beliefs is, "No one has ever told me that before!" This is often stated in a way that conveys intense interest and even pleasure with the interpretation. There are a smaller number of patients who will question the interpretation in a way suggesting they are trying to determine how committed the therapist is to its correctness. When the therapist's conviction does not seem reduced, the patient sometimes brings forth additional information confirming the interpretation.

Interpretations regarding the patient's pathogenic beliefs and unconscious guilt contain the implication that this guilt is irrational. This often assists patients to restore control over themselves and to feel less need to suffer from such guilt.

For example, consider a patient who presents himself as immobilized by depression and explains that this is so only because his girlfriend has recently left him. The interviewer, however, may reach an alternate conclusion from the clinical material. He may decide that the patient is experiencing unconscious guilt because his girlfriend's departure has reinforced

in him a particular unconscious pathogenic belief, in this case, that he hurt his mother by his early autonomous behavior, including his leaving home at an early age. He may be taking his girlfriend's rejection of him as a deserved punishment for having hurt his mother by leaving her.

In this situation the therapist might indicate to the patient that he has an exaggerated concern that he damaged his mother by leaving home to lead a life of his own. Such an interpretation may relieve the patient's unconscious guilt. It may also assist the patient in identifying with the therapist's superego, one which is less harsh than his own.

The use of an initial interview which is not time-limited also contributes to the reduction of unconscious guilt. In this approach the therapist and the patient work together collaboratively until progress is made towards understanding and disconfirming the patient's pathogenic beliefs. Patients are treated with respect and as though they are worthy of careful consideration. Consequently, many patients who because of their unconscious guilt have felt undeserving can in these interviews feel important without experiencing guilt.

Having, more or less, unlimited initial interview time also liberates the therapist from the usual constraints of therapy associated with the fifty minute hour. The therapist can take as much time as he needs without feeling pressured to end his work before he has a sense of completion.

The general approach described here does not try to reduce guilt by manipulation. Reassuring the patient that he has done nothing wrong does not, in and of itself, seem helpful in reducing unconscious guilt. The patient must experience more than this. He must gain an understanding of how his unconscious pathogenic beliefs sustain his guilt.

Brief Comment on the Range
of Applicability of this Approach

It is not our belief that all of the emotional disorders observed in a mental health setting are due to unconscious guilt. However, we have found that irrational guilt seems to make a major contribution to the development of psychopathology in the patients we work with and that focusing more attention on it has improved our understanding of these patients and our treatment results.

We are currently trying the approach described with the full range of mental disorders. Our preliminary findings suggest that it may be useful even for some kinds of severe character disorders and psychotic disorders that have not been very responsive to previous treatment efforts.

Case Example

I will now present a case to illustrate the orientation and approach I have described.

The patient was a thirty-five year old married student who made a drop-in

visit to request emergency services at the Community Mental Health Center. She stated she could not wait for an appointment.

She related symptoms reflecting depression including insomnia, feeling immobilized, frequent crying and suicidal thoughts. She cried profusely while delineating her symptoms but stopped at one point to state: "This is not a crisis." Later in the interview, after she had regained her composure, she noted we had been talking for some time and wondered if the therapist might not need to see someone more distressed than she.

The patient reported that she was very concerned because her brother-in-law whom she greatly disliked was moving into her neighborhood. From her description of this man it was clear that she saw him as a needy person who was under stress, was not coping well with the many problems he had and who repeatedly tried to manipulate her into assisting him by suggesting she was selfish not to do so. She described him as being like her father in that she didn't get along with either of them and they were both inflexible. She said she was "tired of being nice" to him, but she didn't think it was right not to continue.

The patient stated that she had a very strict father who had severely abused her physically as a child. He would beat her for talking back to her mother. Her father was also invariably critical of the boys she dated. When she was in high school, he refused to let her engage in some of the social activities such as being a pom-pom girl, but she secretly participated anyway. She said she tried very hard to please him, for example, by doing very well in school, but couldn't get a favorable response. She went to college on her own without any encouragement from her parents to do so. Her father became mildly physically disabled at this time.

When she became employed, her father took her earnings but refused her permission to do many of the things she wished, such as to go to parties. Consequently, at age 21 she left home. Because of this, her father refused to speak with her for five years. She returned to live at home briefly several times during this period.

The patient described her mother as being paranoid because she was always worried that her husband was having an affair, even though there was no evidence of this. She stated that her parents had constantly argued and she felt they had a very unhappy marriage. She added later that her own marriage was also unsatisfactory.

The patient said her mother had had surgery to improve the appearance of her nose but that the nose was "butchered" in the attempt.

The patient related that she had done well in most of the things she had tried to accomplish. She stated she had recently done an outstanding job on the first piece of sculpture she had created at school. She said about it, "I'm almost afraid to tell people it's my very first piece."

Near the end of the interview the patient wondered if she should come back a second time or not. The therapist interpreted this question to her as a possible manifestation of her discomfort with considering herself important

and deserving of more therapy. He then offered her an appointment which she accepted.

Discussion of Case

The situational stress that precipitated this patient's crisis was the impending move of her brother-in-law. Consciously, she was experiencing great anxiety and some depression which she related to feeling she would be intruded upon by this disliked relative. Unconsciously, she had the pathogenic belief that she would harm him if she did not submit to and take care of him. This feeling made her very uncomfortable because she also wanted to control her own life. Unconsciously, however, she did not believe she deserved this. She also felt unconscious guilt for disliking this man who tried to manipulate and dominate her.

The pathogenic belief which led to this patient's unconscious guilt towards her brother-in-law probably developed in the context of her childhood relationship with her father. She reported having observed that when she had behaved independently, e.g., in speaking up to her mother or later in leaving home, that her father seemed very upset by this. She consequently came to believe that not only her father, but others as well, were vulnerable to being hurt by her if she exercised autonomy and did not submit to them.

While this patient felt unconscious guilt for having hurt her father, she also did not feel comfortable about allowing his domination. Her unconscious conflict in this area was probably manifested in her returning home on several occasions.

The patient also felt that if she was proud of herself, became important or gained recognition, she would distress others. This pathogenic belief may have originated in part from her experience that her father failed to show any interest in her high level of academic achievement and he strongly discouraged her getting other attention, e.g., as a pom-pom girl. She apparently surmised that her being special would hurt her father and others. This belief is perhaps what kept her from openly taking pride in her sculpture.

The patient's view of her mother as being unattractive and as feeling rejected by her husband probably also contributed to the patient's unconscious guilt. That is, she probably unconsciously believed that she should not be outstanding, or attractive, or successful, or admired or happy in her marriage since she did not deserve to have something of which she felt her mother had been painfully deprived. In her immediate situation she appeared uncomfortable at doing so much better than her brother-in-law.

When during the interview she played down how upset she felt and wondered if the therapist shouldn't be seeing someone more distressed than she, her attitude suggested that she was testing the therapist to see whether or not he would take her concerns seriously.

These conclusions with respect to both content and testing behavior were shared with the patient. The patient was informed that her comment

about not being in a crisis and her inquiring as to whether the therapist should spend his time with someone else instead of her might be manifestations of an exaggerated worry or concern for others which led her to feel she should take care of their needs at her own expense. Her anxiety over the impending move of her brother-in-law was also interpreted to her as stemming from a belief that she should take responsibility for his welfare and submit to his demands so as not to cause him distress. It was also explained to her that she had probably developed an early undue concern that her father would suffer if she was independent. It was further suggested that that belief was still making it difficult for her to be comfortable with her wish for autonomy.

In short she was informed as to the source and nature of her pathogenic belief that if she did not submit to others even at the expense of her own autonomy, then she would harm them.

Since this patient showed considerable ability to integrate this material, an additional interpretation was offered to her. It was explained that she also unconsciously believed she could hurt others if she enjoyed success and happiness.

The patient left the initial interview smiling. She related in the second interview that she had talked with her husband about what she had learned and she was pleased because she now felt more free to ask him to treat her better. She gave examples of instances where she had chosen to put her needs first with others in circumstances where she had been painfully reluctant to do so before. Recalling that the therapist had said she tended to put herself second, she made it a point to seek out her brother-in-law and to tell him not to put her second. On the third, and by her choice, the last interview, she said that things were continuing to improve. She then reported how a teacher who was pleased with her work had hugged her and how she was more able to enjoy this very special attention without embarrassment.

The therapist's interpretations seemed useful to this patient in helping her begin to disconfirm her pathogenic beliefs that if she was independent or happy or successful this would be at the expense of others. Consequently her unconscious guilt was reduced and she felt more free to be autonomous and enjoy her successes.